

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF MASSACHUSETTS

\* \* \* \* \* 13CV10974-ADB  
MEGAN IRWIN and \*  
THOMAS IRWIN \*  
VS. \* SEPTEMBER 30, 2015  
\* 10:50 A.M.-12:54 P.M.  
\*  
ECLECTIC DINING, INC. \*  
\* BOSTON, MA  
\* \* \* \* \*

BEFORE THE HONORABLE ALLISON D. BURROUGHS  
DISTRICT JUDGE  
(Jury Trial)

**VOLUME III**  
**EXCERPT TRANSCRIPT**

**APPEARANCES:**

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I N D E XPLAINTIFF WITNESSPAGE

Dr. Mary Hibbard  
Direct Examination by Mr. Charnas

5

1 30 SEPTEMBER 2015 -- 12:50 A.M.

2 (The jury is not present for the following)

3 THE COURT: Is there anything we need to do this  
4 morning?

5 MR. LAWLER: The only thing that I wanted to  
6 address was I did reach my expert late last night, and  
7 I've communicated with him, and he basically says that  
8 his opinions are going to stay the same. He will  
9 comment, I would assume, like the other experts, that  
10 the records show that, since the taxi accident, or  
11 following the taxi accident, she reported her headaches  
12 were more severe.

13 THE COURT: Fair game.

14 MR. CHARNAS: No problem.

15 THE COURT: All right. I'm not concerned about  
16 him standing on an opinion that he already has; I'm  
17 concerned about an opinion that is sufficiently  
18 different that the person that is prepared for the  
19 cross-examination is disadvantaged. We'll give you the  
20 same -- I'm concerned about it on both your behalfs.

21 MR. LAWLER: I would never do that.

22 THE COURT: Okay. So, an opinion that's in the  
23 same ballpark is going to be fine, but a sea change  
24 we'll talk about.

25 MR. LAWLER: All right. And I would expect that

1 rule would apply to both sides, Your Honor.

2 THE COURT: I was supposed to speak on this WBA  
3 panel last night -- this is off the record.

4 (Discussion off the record)

5 (The jury is present for the following)

6 THE COURT: Good morning, everyone. Obviously,  
7 we're getting started a little late. I know the  
8 weather was difficult today, and I'm sure there were  
9 travel challenges, but I'm going to really grovel this  
10 afternoon and beg you all to be here on time tomorrow,  
11 but I will save the groveling for 4:00 instead of at  
12 11:00.

13 What I will say is that the timing is a little  
14 bit challenging. Mr. Charnas has witnesses for today  
15 and tomorrow that had some scheduling challenges, and  
16 we need to complete their testimony by the end of day  
17 tomorrow, so we need to try and make up the time today  
18 because he already had them tightly scheduled.

19 So, what we're going to do is skip the morning  
20 break, and we're going to cut the lunch break to half  
21 an hour, but we ordered you lunch that you'll have in  
22 the jury room. Hopefully, we've gotten something that  
23 everybody likes, but if not, you'll have a half an hour  
24 to run downstairs or do whatever it is you want to do,  
25 but we're cutting the lunch break, and we're providing

1 lunch. I'm sorry for the inconvenience. I'm sorry for  
2 the lack of break time, but it's just these two days,  
3 we just don't have any flexibility in the schedule at  
4 all.

5 So, I'm not going to waste any more time.  
6 Mr. Charnas, call your witness.

7 MR. CHARNAS: Thank you, Your Honor.  
8 Dr. Mary Hibbard.

9 (The Witness Was Sworn)

10 THE CLERK: You may be seated. Can you please  
11 state your name and spell your last name for the  
12 record.

13 THE WITNESS: Mary -- I can't see you.  
14 Mary Hibbard, H -- Mary, M-a-r-y, Hibbard, H-i-b, as in  
15 boy, b as in boy, a-r-d, as in David, 733 Forest  
16 Avenue, Larchmont, New York.

17 MR. CHARNAS: May I proceed?

18 THE COURT: Yes.

19 MR. CHARNAS: Thank you, Your Honor.

20 **DIRECT EXAMINATION BY MR. CHARNAS**

21 Q. Dr. Hibbard, tell the jury, what is your  
22 occupation?

23 A. I'm a licensed psychologist in New York State.

24 Q. And are you a neurorehabilitation psychologist?

25 A. That's the specialty of psychology I have focused

1 on, yes.

2 Q. Tell the jury, what is a neurorehabilitation  
3 psychologist?

4 A. There are many -- there are many types of  
5 psychologists. There are behavioral psychologists,  
6 there are industrial psychologists. I'm in the world  
7 of rehabilitation. I have worked in rehabilitation  
8 settings for the last 30-odd years.

9 THE COURT: Dr. Hibbard, can I ask you to keep  
10 your voice up just a little bit?

11 MR. CHARNAS: I don't think the microphone is in  
12 the right position for her, Judge.

13 THE WITNESS: It may not be. I usually have to  
14 swallow it. Is that better?

15 THE JUROR: Yes.

16 A. Okay. The world of rehabilitation is aimed at  
17 working with individuals who have had some sort of  
18 life-threatening disability or illness and to maximize  
19 their functioning.

20 In order to do that, as a psychologist, part of  
21 my seeing individuals is to do what they call  
22 neurocognitive testing, which is assessment of thinking  
23 skills as well as mood and symptom complaints. That's  
24 part of my position is to do the assessment.

25 The other half of rehabilitation is to take that

1 information and to work with the individual and to work  
2 with a team of rehab professionals in order to maximize  
3 the person's recovery.

4 Q. Do you deal with people who have traumatic brain  
5 injury in your work?

6 A. Yes, I do.

7 Q. I'm going to ask you to explain for us, what is  
8 traumatic brain injury? And I have a chart which might  
9 be of some help to you.

10 Why don't you tell us, Doctor, first of all,  
11 what is traumatic brain injury?

12 MR. LAWLER: Objection, Your Honor. Sidebar,  
13 please?

14 (Discussion at sidebar)

15 THE COURT: Do you have a qualifier for this?

16 MR. LAWLER: It's lack of foundation.

17 THE COURT: Do you have a qualifier for this?

18 MR. CHARNAS: Well, should I ask her more about  
19 what she does about traumatic brain injury?

20 THE COURT: She's a psychologist. I mean,  
21 she --

22 MR. CHARNAS: I'll ask her about what she does  
23 with the brain. I mean, her whole thing is related to  
24 the brain.

25 THE COURT: But that doesn't mean she's the one

1       that diagnoses them or --

2               MR. CHARNAS: No. The physiatrist is going to  
3       diagnose mild traumatic brain injury. Her job is to --  
4       she determines what impairments are attributable to the  
5       brain injury, so part of her job is she knows about how  
6       the brain functions and how the impairments relate to  
7       that brain function.

8               THE COURT: You need to make that clear. You  
9       need to make it clear that she's not the one that's  
10      diagnosing this plan.

11              MR. LAWLER: It's still -- Judge, so far, we're  
12      three questions in basically. Psychologist is my  
13      subspecialty, and what is mild traumatic brain injury?  
14      It's like them asking one of us that particular  
15      question. There's been no qualifications whatsoever.

16              MR. CHARNAS: Obviously, I'm trying to speed  
17      things up maybe a little too fast.

18              THE COURT: You have to beef it up a little bit.

19              (End of discussion at sidebar)

20      **Q.** Dr. Hibbard, please summarize your education for  
21      us after high school.

22      **A.** Immediately after high school, I went to a  
23      three-year nursing school, which was the mode when I  
24      went in the 1960s. I completed my nursing degree and  
25      then worked as a nurse in leadership positions for six



1 or seven years.

2 At that time, I decided I would change careers  
3 and went back to school to complete a Bachelors Degree  
4 in psychology at Mary Mount College in New York City.  
5 Post completing that, I went on for a dual Masters  
6 Degree at Columbia University, a Masters in education  
7 and a Masters in vocational counseling. It's under the  
8 Educational Psychology Division of the school.

9 I then went on for a Doctorate, and over a  
10 period of close to ten years, I finished my Doctorate  
11 in psychology, in counseling psychology at New York  
12 University.

13 Q. And please summarize your training and experience  
14 in the field of neuropsychology and neurorehabilitation  
15 psychology.

16 A. My psychology experience is very much in-the-field  
17 experience with attending numerous on-going seminars  
18 and conferences as well as on-going team work and grand  
19 rounds, things like that, within a hospital setting  
20 because I work in a hospital setting.

21 I had extensive course work as a psychologist in  
22 a range of clinical testing materials, and I also had a  
23 range of counseling and clinical intervention  
24 experiences both in clinical internships and in  
25 externships during my years in my post -- in my

1        Doctoral program.

2        Q.     Summarize your employment history for us, Doctor.

3        A.     My employment history, I'm doing to skip from  
4        nursing and on to psychology because I think that's  
5        time-sensitive. I began my career as a psychologist  
6        shortly after I finished my dual Masters Degree, and I  
7        joined New York University Medical Center and its Rusk  
8        Institute, which was a world-renowned rehabilitation  
9        center in New York City.

10                I worked there for 11 years as a staff  
11        psychologist. I worked with a variety of individuals  
12        doing research on cancer and adjustment to new  
13        diagnosis of cancer for the first maybe three years of  
14        my experience there as part of an NIH study, National  
15        Institute of Health study.

16                I then went on to do subsequent work for another  
17        branch of the Government, it was a grant from NIDRR,  
18        which was the National Institute of Disability  
19        Rehabilitation Research, and that focused on  
20        individuals with stroke, and I worked with individuals  
21        with left-sided strokes as well as right-sided strokes.

22                I then began to be interested in the world of  
23        traumatic brain injury. It was intriguing to me. It  
24        was much -- it presented as a very large challenge.  
25        Everybody was very different, where there was a lot of

1 commonality with the individuals with strokes, so I  
2 began to focus on traumatic brain injury. I stayed  
3 with traumatic brain injury and began to do research in  
4 the area of traumatic brain injury while I was at NYU  
5 for my initial stay there. I subsequently come back  
6 later on.

7 In that capacity, I again worked with a  
8 colleague on early work on what happens to individuals  
9 living in the community after traumatic brain injury  
10 since, at that point in time, it was the low -- you  
11 know, early '80s, and most people only knew about what  
12 happened to individuals when they were hospitalized.  
13 But in traumatic brain injury, a majority of  
14 individuals are never hospitalized.

15 MR. LAWLER: Objection. Non-responsive. There  
16 has to be a question at some particular point.

17 THE COURT: The question is your employment  
18 history, so just --

19 THE WITNESS: Okay, fine. Thank you.

20 A. I then went on to -- I, along with a team,  
21 transferred up to Mt. Sinai Medical Center, which is  
22 another large hospital in New York City. It too had a  
23 Department of Rehabilitation, and our job was to grow  
24 that Department. It was very small, and my major role  
25 there was to expand the Department of Psychology within

1 the larger Department of Rehabilitation as well as  
2 continue on my work with research.

3 My research continued to focus on -- almost  
4 exclusively on traumatic brain injury, with the  
5 exception of many articles I've written about training,  
6 training both interns and post-Doctoral Fellows,  
7 specifically in the world of traumatic brain injury.

8 I stayed at Mt. Sinai for 25 years and then was  
9 recruited back to become the Director of the Psychology  
10 Department for the Psychology Department I worked for  
11 when I was a newbie and just new in my field, and it's  
12 within the Rusk Institute. I stayed there for five  
13 years, completed what I needed to do in that -- no,  
14 four years -- completed what I needed to do at that  
15 point in time and then have subsequently moved in to a  
16 very small private practice.

17 Q. Do you have experience in evaluating patients with  
18 traumatic brain injury?

19 A. I have extensive experience. I've been evaluating  
20 traumatic brain injury -- individuals with traumatic  
21 brain injury for the last 35 years or more.

22 Q. And, generally speaking, how do you evaluate  
23 people with traumatic brain injury, in general?

24 A. In general? The assessment will consist of a  
25 review of the person's medical chart to see what

1 diagnoses -- were there diagnoses of traumatic brain  
2 injury that are available from the medical chart about  
3 the individual and what the symptoms were that the  
4 person conveys, and do they match the typical cluster  
5 of what a traumatic brain injury is?

6 I will then bring the patient in for an in-depth  
7 clinical interview. The clinical interview is designed  
8 to find out who this person was before the injury, at  
9 what level were they intellectually functioning, what  
10 were their strengths and weaknesses prior, did they  
11 have any medical situations I needed to know about or  
12 psycho-social situations? And then I needed to ask  
13 about, What changed, what happened during the accident  
14 or the injury itself that created the traumatic brain  
15 injury for the individual, and then, What are the  
16 changes they experienced since that period of time?

17 Q. Okay.

18 A. That --

19 Q. Go ahead. Sorry.

20 A. Okay. That typically will be an hour to an hour  
21 and a half, sometimes longer, to understand the  
22 person's perspective of what has happened to them and  
23 what has changed. I will often bring in a family  
24 member. Sometimes I will have the family member with  
25 the person, sometimes I'll have them separately.

1 I will then proceed with doing an extensive  
2 battery of testing. The testing is directed at areas  
3 of functioning that are typically impaired in  
4 individuals with brain injury.

5 I will start with an estimate of what their  
6 pre-injury intellectual functioning might have been  
7 like, then I will do an actual IQ test, which will look  
8 at strengths and weaknesses in the person's verbal and  
9 visual or perceptual abilities. I will then use the  
10 gauge of who this person was pre-morbidly and go  
11 through a series of tests to look at areas of  
12 attention, both visual and auditory attention, simple  
13 and complicated attention.

14 I will look at processing speed, how quickly  
15 somebody can do tasks, how quickly they can read  
16 things, how quickly they can do visual tasks, how  
17 fine -- their fine motor skills, see if they're  
18 impacted. I will then go in to the verbal domain  
19 because often there are problems with -- not overt  
20 problems with speaking but problems with naming things  
21 that they know very well, so I will look at naming  
22 problems, I will look at ability to define abstract  
23 thinking concepts and the like. So, now I've gone  
24 through attention, processing speed and verbal. And  
25 fluency is the other area I would look at.

1           The next area I would look at is visual  
2       perceptual abilities, the ability to see things in  
3       space and manipulate them and make them whole. There  
4       are several tests that are done to look at that area.

5           I then move on to memory. Memory is a  
6       complicated area because I would be looking at memory  
7       for things you hear and memory for things you see, for  
8       memory for things you just heard and for memory for  
9       what you -- for 30 minute later, what do you remember,  
10      that's long-term memory. I will see if prompting helps  
11      the person because that's an important clinical tool to  
12      know about. If somehow we can create artificial  
13      prompts, we may be able to help that person function.

14          And the last area I will look at is the area of  
15      executive function. Executive functions are  
16      frontal-lobe functions, and they are multiple in  
17      nature. They work very closely hand in hand, and if  
18      one or two of those functions isn't working, everything  
19      else doesn't work very smoothly. These skills are  
20      skills such as problem-solving, flexible  
21      decision-making, ability to inhibit responses --  
22      flexible problem-solving, verbal -- those major areas.  
23      There are several areas there.

24      **Q.**   Dr. Hibbard, how do we know that these tests are  
25      accurate in measuring impairments with brain function?

1       A.     Each of the tests that are selected -- or that I  
2     select have been well-normed, standardized on  
3     individuals at different age cohorts, so there could be  
4     20- to 30-year-olds and 30- to 40-year-olds and males  
5     and females by different education levels. So, the  
6     tests are found to be reliable, predictable and  
7     consistent.

8             There are manuals to score all of these tasks.  
9     You follow them very closely when you score each of  
10    these, but you have the information for you about the  
11    person based on their performance on a test, and then  
12    you will look at a norm -- a normative manual to find  
13    out what percentage of their -- of the person's age  
14    group, education group and often -- and gender group,  
15    what's the expectation for that person for that  
16    performance.

17    Q.     Dr. Hibbard, have you taught or trained others in  
18    the field of neurorehabilitation psychology?

19    A.     Yes, I have.

20    Q.     Tell us a little bit about that.

21    A.     For probably 20 -- I would say 20 years of my 25  
22    at Mt. Sinai where I worked in the Department of  
23    Rehabilitation in the Psychology Department, I  
24    developed a pre-Doctoral internship program to train  
25    psychologists in their last year of their Doctoral



1 studies where they come for clinical practice for a  
2 year, and these individuals specifically had sought out  
3 learning about rehabilitation and assessment and  
4 treatment of individuals with acquired disabilities  
5 primarily within the area of brain injury.

6 Q. As part of your training and experience, have you  
7 had to learn about what traumatic brain injury is?

8 A. Yeah, it becomes key because you're the teacher of  
9 it to all of the students.

10 Q. So, tell us about that. How did you learn about  
11 that?

12 A. Well, before I -- I just want to come back.

13 Q. Sure.

14 A. I not only did the internship, but I developed a  
15 post-Doctoral fellowship, which was a two-year  
16 specialized program in the area specific to traumatic  
17 brain injury, diagnosis and treatment. I then  
18 maintained my involvement in the clinical internship  
19 and the post-Doctoral program when I went back to NYU,  
20 so I've been involved with training.

21 I was an active lecturer for many of the  
22 courses. I routinely saw patients with the students  
23 under my supervision and modeled and educated about  
24 brain injury and what tests were the most selective for  
25 that individual.

1 Q. Okay. Have you ever given lectures to medical  
2 professionals in regard to --

3 A. Yes, I have.

4 Q. -- traumatic brain injury?

5 A. Yes, I have.

6 Q. Please tell us about that.

7 A. I have done numerous, numerous lectures,  
8 probably -- I don't -- I can look. It's over a hundred  
9 lectures nationally. Internationally and regionally,  
10 I've done many, many more. The majority of lectures  
11 are related to topics specific to traumatic brain  
12 injury and individuals coping with same.

13 Q. In the last ten years, have you been affiliated  
14 with any hospitals?

15 A. In the last ten years? The last ten years, I've  
16 been affiliated with Mt. Sinai Medical Center where I  
17 was a full Professor of Rehabilitation Medicine and so  
18 as part of their academic faculty. I was -- when I  
19 transferred back to NYU, I was again given a full title  
20 of Rehabilitation Professor, and I have maintained that  
21 title even in retirement -- or semi-retirement.

22 Q. What type of patients did you see at NYU, with  
23 what kind of problems?

24 A. At NYU, I was the oversight person for all  
25 individuals coming to the Psychology Department, but my

1 personal work was entirely with individuals with  
2 traumatic brain injury.

3 Q. Now, can you break that down further in to  
4 patients you see -- you saw then in terms of the  
5 different types of brain injuries you dealt with?

6 A. Just at NYU or in general?

7 Q. In general.

8 A. In general? Okay.

9 I saw many, many individuals who've had both  
10 left- and right-hemisphere strokes because that was  
11 part of my earlier research, and earlier research  
12 always involved assessment of these individuals as well  
13 as creation of novel interventions.

14 For individuals with traumatic brain injury,  
15 traumatic brain injury is more common in its  
16 presentation clusters, meaning individuals are  
17 struggling with specific physical problems, cognitive  
18 problems and emotional problems. Having said that,  
19 each person I see is a snowflake. Everyone is  
20 different. They have different residual skills and  
21 different residual deficits that are really tripping  
22 them up in their everyday functioning. So, it's very  
23 hard to categorize other than the commonality is the  
24 diagnosis of traumatic brain injury.

25 Having said that, I've seen people who were

1       barely post-coma or in coma emergence to try to do an  
2       evaluation at bedside, I've seen people in nursing  
3       homes, I've seen people who have come to the Outpatient  
4       Department. My predominant focus has been not  
5       inpatient work but outpatient work, so my vast  
6       experience is with individuals who present with mild to  
7       the most severe injuries.

8       **Q.**   Generally speaking, what does it mean to be  
9       Board-certified in a medical field?

10      **A.**   To be Board-certified is to procure an advanced  
11      specialty recognition by your field. It will be  
12      different for medicine and psychology. In the medical  
13      world, it's a standardized test. In psychology, it's a  
14      standardized test that is used.

15      **Q.**   Is there a Board certification given in the field  
16      of neurorehabilitation psychology?

17      **A.**   The area is more broad. It's in rehabilitation  
18      psychology with many people having specialties  
19      underneath it, but there is, and I have a Diplomate. I  
20      procured it in late 197 -- 1990s.

21               And I had served on the Board of the Psychology  
22      Diplomate for many, many years, have recently stepped  
23      down the last two years but continue on mentoring  
24      psychologists who are preparing to go through that  
25      process so that they hopefully succeed.

1 Q. Dr. Hibbard, have you won any awards or honors in  
2 your field?

3 A. Yes, I have.

4 Q. Could you tell us about just a few of those?

5 A. Okay. Well, I'll just pick a few. The first one  
6 that was noteworthy for me was that, in 1986, myself  
7 and colleagues had won a Sidney Licht Award for  
8 scientific writing by the American Congress of  
9 Rehabilitative Medicine, and this one was on a study  
10 involving stroke patients.

11 I've gotten both -- the Ted Weiss Consumer  
12 Advocacy Award from the Brain Injury Association of New  
13 York State. I've also gotten the Champion of Hope  
14 Award from the same organization.

15 Q. You can just stop there, Doctor, in the interest  
16 of time.

17 Have you published any peer-reviewed articles in  
18 the field of brain injury?

19 A. Yes, I have.

20 Q. And can you just tell us a few of those?

21 A. Okay. All right.

22 Q. You're looking at your curriculum vitae, I take  
23 it?

24 A. Yes, I am. Yes.

25 Here's one I've just picked out of the random

1 group of 42 that I've published with myself as primary  
2 or one of the peer reviewers. O'Neill, Hibbard, et al,  
3 "Personal and Social Costs and Benefits of Working  
4 After Traumatic Brain injury" in the "Journal of Head  
5 Trauma Rehab" in 1998.

6 I have one in a -- on primary Hibbard, Uysal  
7 Kepler, Bogdany and Silver, John Silver who's a  
8 psychiatrist, "Axis I Psychopathology in Individuals  
9 with Traumatic Brain Injury."

10 Q. Let me stop you there. Have you written any books  
11 or chapters in books having to do with traumatic --  
12 with the evaluation or treatment of traumatic brain  
13 injury?

14 A. I've written chapters but not books.

15 Q. Chapters in books; right?

16 A. I know better than to do a book.

17 Q. Okay.

18 A. All right.

19 Q. Can you give us one or two of those?

20 A. Sure. Let me get one to match. Okay. There's a  
21 lead chapter by Gordon and myself in 2005 called,  
22 "Cognitive Rehabilitation" and it's in John Silver's  
23 book -- John Silver, McAllister and Yudofsky, "Textbook  
24 of Traumatic Brain Injury."

25 Q. Now, just so it's clear, the Gordon that you wrote

1       that with is not the Dr. Barry Gordon that's the  
2       defense expert in this case?

3       A.    No.   This is Dr. Wayne Gordon.

4       Q.    Thank you.  Doctor, you've mentioned traumatic  
5       brain injury several times.  Can you tell us what  
6       traumatic brain injury is?

7           MR. CHARNAS:  And, Your Honor, if I could have  
8       the chart now?

9           THE COURT:  Yes.

10          MR. CHARNAS:  Thank you.

11          MR. LAWLER:  Same objection, Your Honor.

12          THE COURT:  Overruled.

13          MR. LAWLER:  Thank you.

14       Q.    Doctor, tell us, what are we looking at here?

15       A.    What are we looking at here?

16       Q.    Yeah.

17       A.    We're looking at the brain, the inside of -- on  
18       the inside of our skull.  The outside covering is the  
19       skull.  The brain itself is divided -- well, I'll first  
20       say this brain here that looks kind of firm is kind of  
21       Jell-O consistency, it's very fluid.  But within it,  
22       there are areas of specialization, and over time we  
23       continue to find new areas of specialization in  
24       understanding the brain.  It's a very complex organ.  
25       The primary divisions of the brain are the frontal

1 lobe -- does this circle? No?

2 Q. No.

3 A. It doesn't, okay. All right. The frontal lobe is  
4 blue; the temporal lobe, which is over your ears here,  
5 are a dark blue; at the back is your occipital lobe;  
6 and behind the frontal lobe on top is the parietal  
7 lobe; you also have a cerebellum, which is down  
8 underneath; and a brain stem. That's the global  
9 outside view of a brain.

10 Q. Can you tell us, what is traumatic brain injury?

11 A. Traumatic brain injury is when the brain  
12 experiences a significant force that causes damage to  
13 it. The damage can be transitional and short-lived, or  
14 it can be permanent. The most typical traumatic brain  
15 injury --

16 MR. LAWLER: Objection.

17 THE COURT: Sustained.

18 MR. LAWLER: Non-responsive.

19 THE COURT: Sustained.

20 Q. Are there different kinds of brain injury,  
21 traumatic brain injury?

22 A. Yes.

23 Q. What's the most typical?

24 A. The most typical traumatic brain injury is a  
25 frontal-impact injury. For example, if someone in a



1 car gets stopped short and doesn't have a seatbelt on  
2 and crashes through the windshield, frontal injury,  
3 okay?

4 That will impact this lighter blue area of the  
5 visual, mostly on the front part of the brain -- front  
6 part of the frontal lobe and as it goes underneath  
7 because that frontal lobe really wraps the front of the  
8 brain itself. It is -- the damage as a result of a  
9 traumatic brain injury is that whatever the functions  
10 are in the areas of that anterior frontal lobe, as well  
11 as the front part or the anterior part of the temporal  
12 lobe, which is underneath it sitting over our ears,  
13 those are the areas that are primarily impacted in a  
14 frontal injury.

15 The impact itself is because the brain is a  
16 fluid mass. It has cerebral spinal fluid floating  
17 around it, which keeps it kind of protected, but it's a  
18 very fragile thing. And if you hit a fragile mass,  
19 you're going to cause a lot of pressure on that brain  
20 itself. That pressure compacts the brain and makes it  
21 literally move back and forth in the skull, and it also  
22 causes it sometimes to rotate.

23 It's connected, remember, to the brain stem.  
24 So, you have a brain stem, and you have this brain, and  
25 the brain starts to rotate and go back and forth.

1 Well, if you take a brain that's the consistency of  
2 Jell-O and you start doing that to it, you're starting  
3 to change the structure of the Jell-O or the brain.  
4 The problems will go through the entire --

5 MR. LAWLER: Objection.

6 THE COURT: Okay. He's asking a question, and  
7 you're answering more broadly than the question he's  
8 asking.

9 THE WITNESS: Okay. Sorry.

10 THE COURT: So, if you could try and listen to  
11 his question and answer it. He's very good. He will  
12 certainly ask you the next question.

13 THE WITNESS: Okay.

14 MR. LAWLER: Thank you, Your Honor.

15 Q. Which is, what is mild traumatic brain injury?

16 A. Mild traumatic brain injury is a terminology, one  
17 of several. You could have a mild, a moderate or a  
18 severe traumatic brain injury. The initial definition  
19 of mild is based on EMS, Emergency Medical System, and  
20 ER interventions with how impaired the person is and  
21 what they are presenting as symptoms. There is a  
22 measure called the Glasgow Coma Scale --

23 MR. LAWLER: Objection, Your Honor. Request  
24 sidebar at this point.

25 (Discussion at sidebar)

1 MR. LAWLER: It's well-established that jurors  
2 get aggravated at counsel when they have to object  
3 constantly. I have to object constantly now because  
4 Mr. Charnas is trying to put Dr. Hibbard on autopilot.

5 THE COURT: I don't actually think he's trying  
6 to do that. I think the witness is on self-autopilot,  
7 but you've got to --

8 MR. CHARNAS: I know. I'm trying to speed  
9 things up, Judge, and --

10 THE COURT: I know, but --

11 MR. CHARNAS: And she's on autopilot too.

12 THE COURT: She's on autopilot, but you've got  
13 to -- she's going well beyond the questions that you're  
14 asking. I'll instruct her again.

15 MR. CHARNAS: That's not necessary.

16 MR. LAWLER: Thank you. Well, I would like an  
17 instruction again.

18 (End of discussion at sidebar)

19 Q. Dr. Hibbard, what's the difference between mild,  
20 moderate and severe traumatic brain injury?

21 A. The difference is in the degree of altered mental  
22 state or consciousness immediately post the injury, how  
23 long a period the person has a period of total loss of  
24 memory after the event, and the last criteria is did  
25 they have a loss of consciousness or not.

1 Q. Can someone who sustains mild traumatic brain  
2 injury have serious consequences?

3 MR. LAWLER: Objection. Leading.

4 THE COURT: Overruled.

5 A. The literature would suggest that 20 to 30 percent  
6 of individuals with mild injury are likely to remain  
7 with permanent, ongoing problems for the rest of their  
8 life.

9 Q. And would those problems be serious even though  
10 the brain injury is called mild?

11 A. Mild is a euphemism for living with a mild brain  
12 injury with persistent symptoms.

13 Q. Now, Doctor, in your work as a neurorehabilitation  
14 psychologist, from time to time, do medical doctors ask  
15 you to perform neuropsychological evaluations on their  
16 patients?

17 A. Yes, they do, routinely.

18 Q. And what types of doctors, what specialties  
19 generally tend to ask you to do these evaluations?

20 A. Neurologists traditionally are the individuals who  
21 will ask you to see a patient because the person has  
22 had a significant blow to the head, and they're worried  
23 about them.

24 The area of rehabilitation medicine has  
25 physicians who are specifically trained in

1 rehabilitation medicine, and they're called  
2 physiatrists. Physiatrists are not psychiatrists;  
3 they're physiatrists, and those individuals will  
4 routinely recommend evaluation.

5 Q. When you're asked to do these evaluations, what  
6 type of evaluations do they ask you to perform?

7 A. They will ask me to do a neuropsychological  
8 evaluation. They do not ask for, Do this test or that  
9 test. That's within the realm of the psychologists to  
10 choose.

11 Q. So, generally speaking, what are you testing for?

12 A. I'm testing for the area -- I'm testing, A, based  
13 on the person's self-complaints, to be sure I'm testing  
14 areas that would reflect the intactness or lack of  
15 intactness of those areas, that's the first and  
16 foremost.

17 And then I would go through the areas of  
18 cognitive impairments that are most typically shown in  
19 individuals with brain injury. I would look at areas  
20 of attention, memory, processing speed, visual  
21 perceptual functioning, executive functioning. I would  
22 also evaluate how the person's mood is and their  
23 anxiety levels.

24 Q. Is that called affective functioning?

25 A. Yes, affective functioning.

1 Q. When a doctor asks you to do a neuropsychological  
2 evaluation, do you yourself do the tests, or do you  
3 have someone else do the tests for you?

4 A. I always do the tests myself.

5 Q. And is that important?

6 A. It's extremely important.

7 Q. Why is that?

8 A. Because you get to see the person, first of all,  
9 How is their stamina over a period of an hour? Do they  
10 begin to get flustered as the hour went on? So, you're  
11 looking at clinical information there. You can see  
12 when the person gets overwhelmed. You can see when  
13 they break down and cry because they're so frustrated.  
14 You don't get to see that if somebody else is doing the  
15 testing and all you have is data to look at.

16 Q. Doctor, at some point, did I ask you to do a  
17 neuropsychological evaluation of Megan Irwin?

18 A. Yes, you did.

19 Q. And do you remember approximately when that was?

20 A. I can give you the exact dates. It was 3/20/14,  
21 3/26/14 and 4/01/14.

22 Q. That's when you performed the evaluation?

23 A. That's correct.

24 Q. And what did you do in order to perform this  
25 neuropsychological evaluation of Megan Irwin?

1       A.     My initial steps in meeting -- before I met Megan,  
2       was to do a medical chart review. Mr. Charnas had  
3       provided medical chart information for me to review.

4             What I found in the medical review was multiple  
5       areas of consistency across physicians, both --

6             MR. LAWLER: Objection.

7             THE COURT: Is that the same objection we talked  
8       about?

9             MR. LAWLER: Yes, Your Honor.

10            THE COURT: Dr. Hibbard, you have to just answer  
11       the question that's asked. I know you may be able to  
12       surmise what his next question is going to be, but you  
13       have to wait for him to ask it.

14            THE WITNESS: Okay, thank you.

15       Q.     So, Doctor, when I asked you to do a  
16       neuropsychological evaluation of Megan Irwin, what did  
17       you do?

18       A.     I did a medical chart review to look at symptoms,  
19       diagnosis of traumatic brain injury and consistency  
20       across the chart. I then brought Megan in for a  
21       clinical interview where I focused on her -- who she  
22       was before, her pre-morbid abilities, her education,  
23       her family background, her academics, medical problems  
24       she had --

25            MR. LAWLER: Objection. The question was: What

1 did she do, Your Honor.

2 MR. CHARNAS: And she's telling us, Judge.

3 THE COURT: Yeah, she's -- I'm going to overrule  
4 that objection.

5 MR. LAWLER: Thank you.

6 A. Let me get grounded again.

7 The -- I'll ask who she was -- who Megan was  
8 before this event happened, this accident happened, and  
9 then I will ask changes subsequent to that in her  
10 functioning, what she tells me spontaneously. I will  
11 also review symptoms that she's reported on checklists  
12 and things like that I then reviewed within session.

13 I, in this case, interviewed the husband on the  
14 telephone. I then proceeded to begin testing. I went  
15 through all of the areas I've talked about that are  
16 typical in traumatic brain injury. The one additional  
17 area that you need to look at is an area of effort on  
18 testing to be sure that the person is trying their best  
19 and personality considerations.

20 Q. And did you arrive at certain opinions concerning  
21 Megan Irwin's cognitive and affective functioning?

22 A. Yes, I did.

23 Q. And do you hold those opinions to a reasonable  
24 degree of certainty?

25 A. I do.



1 Q. And what is your opinion?

2 MR. LAWLER: Objection. Foundation.

3 THE COURT: I'm not sure I understand the  
4 objection. Do you want to talk about it at sidebar?

5 MR. LAWLER: Yes, Your Honor.

6 (Discussion at sidebar)

7 MR. LAWLER: Again, the objection is lack of  
8 foundation.

9 THE COURT: To make an opinion in general or on  
10 that particular question, an overall lack of  
11 foundation?

12 THE COURT: Overall lack of foundation.

13 THE COURT: Okay. That's overruled.

14 MR. LAWLER: Your Honor, she basically is saying  
15 I'm giving her these tests --

16 THE COURT: Yeah.

17 MR. LAWLER: -- and do you have an opinion based  
18 on these tests, and yes, she's going to basically say,  
19 I do have an opinion, and now what is that opinion? So  
20 now it's time for me to object. She hasn't established  
21 what tests were given to Ms. Irwin, what the interview  
22 consisted of. I mean, she's produced, I don't know, a  
23 30- to 40-page report in this particular case that  
24 talks about all these different elements of it, and now  
25 basically because he wants her to cut to the chase,

1 none of this is brought forward.

2 THE COURT: Well --

3 MR. LAWLER: First you want him to go through  
4 every test that she did. This goes to the weight of  
5 the evidence. She's qualified for her expert opinion.  
6 He's asked her for her opinion.

7 MR. CHARNAS: Your Honor, the law is clear. I'm  
8 entitled to get her opinion and then ask for a basis  
9 for it. And I'm beginning to think that these multiple  
10 objections are designed to make it take longer and  
11 longer for this witness. He knows I'm under time  
12 pressure, and he's making these multiple objections.

13 THE COURT: I'm going to overrule that  
14 objection. You can get to it on cross.

15 MR. LAWLER: I will, thank you.

16 (End of discussion at sidebar)

17 THE COURT: That objection is overruled.

18 Q. Did you arrive, once again, at certain opinions  
19 concerning Megan Irwin's cognitive and affective  
20 functioning?

21 A. Yes, I did.

22 Q. Do you hold those opinions to a reasonable degree  
23 of certainty?

24 A. Yes, I do.

25 Q. Tell us, what is your opinion?

1       A.    My opinion is -- my psychological diagnoses were  
2       cognitive disorder, a thinking disorder secondary to  
3       traumatic brain injury, a mood disorder secondary to  
4       the injury, an adjustment disorder secondary to the  
5       injury, and a post-traumatic stress disorder secondary  
6       to the injury and the accident itself.

7       Q.    When you say the injury, we're talking about the  
8       injury of August 5th --

9       A.    The traumatic brain injury.

10      Q.    -- 2012, okay.

11           Now, earlier you said that one of the things you  
12      did was you looked at the effort that Mrs. Irwin was  
13      giving?

14      A.    Correct.

15      Q.    Why is that important?

16      A.    Because of the potential of secondary gain,  
17      someone is feigning potentially or making believe  
18      they're doing worse than they really could do on  
19      testing. So, in order to counter that, there have been  
20      a whole range of measures used to look at effort and  
21      the adequacy of effort. Some of the tests are tests  
22      all by themselves, and some are embedded measures.

23      Q.    And did you prepare a chart for us of a summary of  
24      these tests that you did to test her effort?

25      A.    Yes, I did.

1           MR. CHARNAS: And Your Honor, I'd like to show  
2 this chart to the jury.

3           THE COURT: Go ahead.

4           Q. So, if you would, tell us, what are we looking at  
5 here on this chart?

6           A. Okay. We're looking at four different components  
7 of measures of effort that I used in this evaluation.  
8 They were sampled throughout the testing, so the person  
9 had no idea when I was using these particular tests.

10           The first one was a component of a verbal  
11 learning test. It was a list of words that Megan had  
12 to remember after being repeated multiple times, and  
13 then I asked her in a half an hour to remember those  
14 words again, and the California Verbal Learning Test at  
15 the very end has a fairly simple, Which of these words  
16 did you hear in the list that I kept reading? Is this  
17 this or this? And the person has to choose which of  
18 those answers are correct. Megan correctly identified  
19 16 of the 16 words that were on that list in that  
20 format. That's an embedded measure of effort.

21           The second test I used is a stand-alone test of  
22 effort. This is a series of simple pictures called the  
23 Test of Memory and Malinger. The person is shown 60  
24 simple visual pictures, like a picture of a birdhouse  
25 or a whistle -- okay? -- and then is asked to choose

1 from two items, Which has she seen before? So, in this  
2 case, if there was a whistle and an alarm clock, the  
3 answer would have been whistle. You will do these 50  
4 items and then the choice of 50, 50 from choice of two  
5 items, and then depending on a cut score on how well  
6 she does on that test, you may have to do it again.

7 In Megan's case, the first time she saw these  
8 50 items, she picked 34 out of the 50 when given a  
9 multiple choice between two items. That was low. It  
10 was not passing score. A passing score needs to be 45  
11 or higher. So, I needed to re-administer the test  
12 again. I re-administered the test in the same way,  
13 showing her the 50 pictures and then asking her to  
14 choose from an array of two.

15 And this time she did pass, and she got 48 out  
16 of 50. There was one more option if I needed to, to  
17 test the limits, but I didn't need to here. She passed  
18 the test, and her effort was deemed appropriate and  
19 reliable.

20 The third measure on this list is a sub -- is a  
21 different way of scoring one of the components of  
22 attention that I measure, and it's call the Digit-Span  
23 Test where numbers are read in increasing array of  
24 length forward, and then the person has to repeat them  
25 and then backward and the person has to repeat them.

1 For this purpose, a minimum number of digits remembered  
2 forward and backward is the essential measure of  
3 effort. Someone needs to remember at least four  
4 numbers going forward in the right order and four  
5 numbers in reverse order.

6 In Megan's case, she had a total of four numbers  
7 she remembered forward, four number back. The cut  
8 score for this measure is seven, so she is deemed to  
9 have adequate effort.

10 The Rey 15 item is a simple effort measure.  
11 It's 15 very easy items to remember. You pre-cue the  
12 person, I want you to remember these because I'm going  
13 to give you a blank piece of paper and you'll have to  
14 draw them for me, and they're things like a 1, a 2, a  
15 3, a circle, a diamond -- a triangle and a square, very  
16 simple, easy things.

17 For this test, when Megan drew them, she drew 15  
18 out of 15, she got -- 12 out 15, rather. So, she  
19 remembered the majority of them. This score is higher  
20 than nine, which is the cut-off for this measure, so  
21 across the board she presented adequate effort.

22 **Q.** After you determined that she was giving an honest  
23 effort, what did you do next in terms of your analysis  
24 or testing?

25 **A.** My next task was to assess her pre-accident

1 intellectual abilities.

2 Q. Why is that important?

3 A. It's essential because not everybody coming in to  
4 the office comes in with the same basic intellectual  
5 ability. Some people are average, some people are very  
6 superior, some people are borderline to begin with.  
7 So, we need to get an estimate for her so that we can  
8 see what the changes are for Megan relative to who she  
9 was before.

10 There are measures that I will use from her  
11 history, what her college GPA was, what kind of scores  
12 did she have, did she ever fail any tests. I will look  
13 at her academic his -- her work history to see what  
14 kind of work she did, how complex was it and was she  
15 successful in the work or not. Those are indicators of  
16 who this person was pre-accident. I'll also ask about  
17 a family history and how far people went in school.

18 For testing itself, I will use a measure which  
19 is a reading measure, and the words get increasingly  
20 esoteric and hard to pronounce. It's important to  
21 pronounce them correctly. It is in association with  
22 people with more education will have a broader array of  
23 vocational skills and agility.

24 This test is called a test of pre-morbid  
25 functioning, and for Megan, she scored in the average

1 range on that measure. So, her -- the pre-morbid  
2 estimate for testing for Megan is that's her benchmark,  
3 she was average. The average is the range that I will  
4 then use to say that this score at average is intact.

5 Q. Just so it's clear, was it just that test that you  
6 used to determine what her pre-morbid or pre-accident  
7 condition was or functioning was?

8 A. No. To repeat again, that is one component.  
9 That's a standardized measure of pre-morbid estimate,  
10 all right? I would -- as I said, went back to her  
11 history, which often tells you additional information  
12 about the individual that may suggest that whatever  
13 you're going to get on one test may be -- may suggest  
14 her IQ might be a little higher than that.

15 Q. Was there anything specifically about her work  
16 history that you thought was significant when you were  
17 evaluating her pre-morbid functioning?

18 A. Yes, there was.

19 Q. And what was that?

20 A. The -- her ability to take on positions and  
21 rapidly be identified as a superior excellent worker in  
22 the field. Megan worked in -- her first position was  
23 in Yellow Book, which was an advertising group for I  
24 think Yellow Pages or something like that. And she was  
25 quickly identified as Rookie of the Year the first --



1 within the first year she had taken that job. She,  
2 obviously, had done very well in sales.

3 She then went on to Shire Pharmaceutical where  
4 she rapidly -- where her job was to sell medical  
5 products to physicians in their private offices in  
6 Manhattan. Her job was to really go in and sell  
7 medication to physicians, so intuitively, you know,  
8 that would need a great deal of ability to be able to  
9 understand medications that she might be recommending,  
10 what potential side effects there might be, things like  
11 that.

12 She, again, showed incredible ability to excel  
13 at sales in this position. She was there for eight  
14 years. She was senior salesperson up until the time  
15 she had her accident, and she had just been awarded an  
16 achievement award for high sales for the company  
17 several months before her accident. So, it does talk  
18 about some other strengths that she was obviously  
19 showing in her work experience.

20 Q. Dr. Hibbard, what did you do next in terms of your  
21 analysis?

22 A. The -- for testing?

23 Q. Yes.

24 A. Then I would proceed with testing. Testing  
25 usually takes six to eight hours, depending on the

1 individual, and I will not do an area of attention, for  
2 example, only and then move only to memory; I will mix  
3 tests, so that the person has no idea what it is I'm  
4 going to be asking them to do next.

5 Q. Doctor, did you prepare a chart for us, a two-page  
6 chart, summarizing your test findings?

7 A. Yes, I did.

8 MR. CHARNAS: Can everybody read that?

9 Q. Can you read that?

10 A. I can read that.

11 Q. Okay. Well, if you can read it, I can. Okay.

12 A. Right. Let me give you -- this is a lot of  
13 information here, but let me --

14 Q. Let's -- what I'm going to ask you to do is go  
15 through the chart line by line and tell us the  
16 significance of each of these things.

17 A. Okay. All right. The first grid is current IQ.  
18 This was her current IQ post-injury, all right? If you  
19 see the second column -- let me just give you the grids  
20 first; okay?

21 The first column is where Megan's performance is  
22 in the high average or above range. Just because  
23 predicted IQ is average, one could expect that there's  
24 going to be some high intellectual abilities  
25 potentially still intact. Second is average skills.

1 Third is low average. And the last area is impairment,  
2 which falls in the borderline-to-impaired range.

3 Q. So, please go through these columns for us.

4 A. Okay. The first -- the current IQ is a composite.  
5 There's a full IQ score, and a full IQ score is in the  
6 second column here, and it says it's 93, which is  
7 exactly the same as the test of pre-morbid functioning  
8 predicted, interestingly. Rarely do we find that, and  
9 it's at -- so, she stands at the 37th percentile for  
10 her age group.

11 But within the IQ score, and you will often see  
12 this in IQ scores, there are four sub-indexes: There's  
13 a verbal comprehension index for verbal strengths;  
14 there's a perceptual reasoning index for visual  
15 perceptual skills; there is a working memory index,  
16 holding information in short-term attention; and then  
17 there is a processing-speed index. All four combine to  
18 make the IQ.

19 What you will see typically and you see in  
20 Megan's case is that, after the injury, certain  
21 cognitive skills that make up the IQ test are pulling  
22 down some of these scores and keeping others relatively  
23 preserved. In Megan's case, the first column, which  
24 says, "Processing-speed index," was still -- was in the  
25 82nd percentile. That's high average, and clearly this

1 reflects how she used to be able to mutli-task at home,  
2 how quick she could do work and go to school and take  
3 care of the kids and --

4 MR. LAWLER: Objection, Your Honor.

5 A. -- and still be a super-achiever.

6 MR. LAWLER: This is the same objection that I  
7 made before. I mean, this is a non-responsive answer  
8 that's running on to seven minutes now.

9 THE COURT: Dr. Hibbard, he's again objecting to  
10 the fact that you're going beyond the scope of the  
11 question.

12 THE WITNESS: Okay. I will try not to digress.  
13 I apologize.

14 A. Okay. The -- but it is important to know the  
15 difference in the IQ indexes. Her processing speed was  
16 her relative strength in IQ --

17 MR. LAWLER: Objection, Your Honor. There is no  
18 question.

19 MR. CHARNAS: Let me try it, Judge; okay?

20 THE COURT: What he's asked her to do is to  
21 explain the columns, so why don't you try and do that a  
22 little bit more succinctly.

23 THE WITNESS: Okay.

24 THE COURT: Okay?

25 THE WITNESS: Fine.

1 Q. So, we have the processing speed as a cognitive  
2 strength of hers you've told us?

3 A. Correct.

4 Q. And then you've told us that her full IQ is 93,  
5 which -- but her verbal IQ or her verbal index is  
6 58 percent?

7 A. Correct.

8 Q. What is the significance of that, that difference?

9 A. There is no -- there's no significant difference  
10 between the full IQ and the verbal IQ. They're both in  
11 the average range; okay?

12 The significant difference is she's got a  
13 strength in speed of processing. And if you look at  
14 the other columns, she's got weaknesses in two areas,  
15 and the weaknesses are in her perceptual reasoning --

16 Q. That's the next column; correct?

17 A. Yes. -- and working memory. And of those two,  
18 working memory is at the ninth percentile based on a  
19 hundred, so 91 percent of people do better than she at  
20 her age group.

21 Q. Now, this last column, "Functional Implication,"  
22 what are you trying to tell us in that column?

23 A. That any of these tasks that are administered  
24 require some component of working memory, meaning  
25 holding on to the information long enough so you can

1 get to the answer, even if you're thinking about, How I  
2 do I define a word? Well, I won't go further than  
3 that.

4 Q. That's okay.

5 So, basically the first column across, you've  
6 told us she has certain weaknesses; correct?

7 A. Correct.

8 Q. And then those weaknesses reflect in certain  
9 actual functioning problems she's having, as explained  
10 in the last column?

11 A. Correct, and to elaborate later on down here.

12 Q. Right. And so, working memory, so it actually  
13 affects her working memory. Tell us what working  
14 memory is.

15 A. Working memory is to hear new information and be  
16 able to hold on to it and manipulate it in your head so  
17 that you can retain it.

18 Q. Now, the next column down, you're talking about  
19 cognitive functioning by domains. What's a domain?

20 A. A domain is an area of cognitive abilities.

21 Q. So, the column below that, the horizontal column,  
22 it says, "Attention Skills." What are attention  
23 skills?

24 A. Attention skills include attention for things you  
25 see, both simple and complex information; and attention

1 for things you hear, or auditory attention, and those  
2 can be simple or complex information; and your ability  
3 to sustain your attention over a period of time.

4 Q. So, the next column over to the right, one of her  
5 cognitive strengths was simple visual attention?

6 A. Correct.

7 Q. What's that?

8 A. Simple visual attention is looking -- an example  
9 would be seeing symbols on a page, seeing one symbol or  
10 two symbols, you're told you have to remember the  
11 symbol and which one appeared first and second, and  
12 then you're given a choice of four different symbols,  
13 pick out the one that came first and came second.  
14 That's holding on to the information visually so that  
15 you can identify it correctly.

16 Q. That was a strength of hers?

17 A. That was a strength.

18 Q. Now, moving to the right, you found cognitive  
19 weaknesses, and again, these are things you found  
20 through your testing; correct?

21 A. Correct.

22 Q. So, tell us what, in a nutshell, what these things  
23 are, simple auditory attention, et cetera.

24 A. Simple auditory attention, the task used for that  
25 is remembering digits going forward and backward. I

1 already told you about that as a sub-measure of  
2 attention, but -- a sub-measure of effort, rather, but  
3 her overall score here was at the ninth percentile.

4 Q. And the complex auditory attention?

5 A. Complex auditory attention was measured by giving  
6 Megan a series of increasingly complicated math  
7 problems that she had to hold in her head and do, not  
8 use paper and pencil, but to hold in her head, work out  
9 the information and then respond.

10 Q. And that was a weakness?

11 A. And that was weakness.

12 Q. And how about complex visual attention? What's  
13 that?

14 A. Complex visual attention is when she has to hold  
15 on to a complex visual figure in this case. It was the  
16 Rey Complex -- Rey is an example of a complicated  
17 visual design. She needed to hold on to that to be  
18 able to then remember it at a later point in time.

19 Q. Now, a cognitive impairment you found in the  
20 domain of attention skills is in the next column --

21 A. Right.

22 Q. -- and that's sustained attention, et cetera.  
23 Could you explain each one of these, what they are?

24 A. Sure. This is a -- this is called a Connors  
25 Continuous Performance Test. It is a 15-minute task



1 where the person has to sit in front of a computer and  
2 look at a screen and respond as quickly as they can to  
3 a letter flashing on the screen, except for when they  
4 see the letter X. So, any other letter counts but not  
5 X.

6 Her overall score was at a 50th percentile,  
7 which put her at an equal chance of having an attention  
8 problem or not, but when you looked at the  
9 sub-components of the test measures themselves, what  
10 you see is that she has problems with decreasing her --  
11 her performance decreases over time or her accuracy  
12 decreased over time of a 15-minute span of testing,  
13 that she was often impulsive, meaning every time that X  
14 came on, she'd touch the space bar and do what she  
15 wasn't supposed to do; and she had poor vigilance, she  
16 just couldn't keep up the focus on what she needed to  
17 do.

18 Q. So, Doctor, let's talk about the next column to  
19 the right. How did the weaknesses and impairments in  
20 the attention skills, how did they manifest themselves  
21 in terms of how they affect her life?

22 A. One of the things I did was go back to the  
23 self-report measures that she completed prior to coming  
24 in to see me in the office. One of them was called the  
25 Brain Injury Questionnaire. It includes 100 items

1 typically problematic after a brain injury, and what I  
2 looked at were her reports of symptoms on a scale of  
3 "never a problem" to "often" and "always a problem"  
4 that reflected attention problems in everyday life.

5 Q. Oh, can I stop you there for a second? Doctor,  
6 how do you know that she just didn't put down anything  
7 she wanted to put down?

8 A. You can look at the variability in her testing.  
9 She didn't -- she didn't identify all things as  
10 problematic. She was very selective on which things  
11 were always a problem or often a problem. She -- there  
12 is a measure of sensitivity and specificity of the  
13 items on this test specifically for traumatic -- mild  
14 traumatic brain injury, of which I'm co-author, and so  
15 there are ways to assess whether there is a reliable  
16 measure.

17 Q. Did the things that she complained of on that  
18 form, did they match up to your test results?

19 A. They certainly did.

20 Q. And I'm sorry. I interrupted you. You were  
21 telling us about the functional implications.

22 A. The functional implications which she endorsed  
23 were that she sometimes becomes confused in familiar  
24 places, and that could be her local neighborhood. She  
25 admitted to being often easily distracted. She often

1 had difficulty concentrating and reading. She knew she  
2 had problems here. She sometimes loses her train of  
3 thought. There are examples within testing where that  
4 happened.

5 She frequently can't do two things at once. My  
6 analogy is the person can walk or chew gum; they can't  
7 walk and chew gum together and do it well. She was  
8 restricting her driving due to mistakes in her judgment  
9 and will always get easily disoriented. She gets lost  
10 in her own neighborhood. She has trouble following  
11 conversation when there's more than one person talking.  
12 Those are all attention working memory issues.

13 Q. All confirmed by your tests?

14 A. Correct.

15 Q. Now, let's go to the next column down, "Visual  
16 Perceptual Skills." What's that, in a nutshell?

17 A. Visual perceptual skills are seeing the world and  
18 its component parts and being able to make a whole out  
19 of it, so that it's not fragments of life that we see  
20 but a whole picture.

21 Q. And you found that she had some intact skills,  
22 cognitive skills, in that area; correct?

23 A. Correct.

24 Q. And then you found that she had certain cognitive  
25 weaknesses in that area; correct?

1 A. That's correct.

2 Q. Could you go through these cognitive weaknesses in  
3 that box there and tell us what each one is?

4 A. Okay. Her -- the intact skill in the average  
5 range was non-motoric visual perceptual integration.  
6 This task is seeing a picture of, say, a boat that's  
7 been cut up in different pieces and put unusually  
8 around on a piece -- on a page, and the person has to  
9 use their visual perceptual abilities to be able to see  
10 what -- how, if you put those pieces together, would  
11 the puzzle come together and what would it be. So, the  
12 person has to then guess a boat, it's a boat that  
13 they're seeing. She did well on that. She was in the  
14 average range.

15 She also was very good at copying, as long as  
16 visual designs were simple. That requires visual  
17 perceptual integration, How am I going to do this?  
18 What do I need to do first? What do I need to do  
19 second to make this image the same as the thing that  
20 you're showing me at this point? There, on a copy task  
21 within a memory component, her performance was  
22 unimpaired, it was greater than 75th percentile.

23 Q. What about the next column, "Cognitive  
24 Weaknesses" --

25 A. Okay.

1 Q. -- in this visual perceptual skills domain?

2 A. All right.

3 Q. What are these things that you have in the box  
4 and --

5 A. Okay. Visual abstraction, being able to see an  
6 array of five items and something's missing, and you  
7 have to figure out, what's the pattern in those five  
8 items to figure out what the sixth one should be and  
9 then choose it from an array of four or five items.  
10 Megan had problems with this area and ended up in the  
11 low average range.

12 The visual motor perceptual task, it's different  
13 from the non-motor, which she could do in her head, and  
14 that was at the -- that she did fairly well on that.  
15 That was in the average range. This visual motor, she  
16 actually had to take blocks, two-tone blocks and  
17 manipulate them to match a design.

18 She did very well as long as she had only four  
19 blocks to work with. The minute the design changed in  
20 rotation or changed in number, more blocks were needed  
21 to complete a design, she became overwhelmed.

22 Q. Let's talk about the cognitive impairments in the  
23 visual perceptual skills domain.

24 A. All right.

25 Q. What is this copy of complex visual design?

1       A.    We have a -- I think a visual would help on that  
2       one.

3       Q.    And what tests are you talking about, Doctor?

4       A.    The Rey Complex Figure Test.

5       Q.    Now, what are we looking at here, Doctor, on the  
6       left and the right?

7       A.    I'm sorry. I didn't hear you.

8       Q.    Can you see on the screen?

9       A.    Yes.

10      Q.    Okay. So, tell us what is on the left and what's  
11      on the right.

12      A.    Okay. Up in the far corner of the left side of  
13      the screen here is an examiner's version of what is a  
14      complex visual design. The numbers on it ignore for  
15      the moment. The person is presented a piece of paper  
16      with this large figure drawn on a page without the  
17      numbers, remember; okay? And the instruction is, I'm  
18      going to give you a piece of paper, and I want you to  
19      draw this exactly as you see it.

20            So, the person has no memory involved, she can  
21      just see the design and then copy it herself. This  
22      requires complex visual perceptual skills. You need to  
23      know, How am I going to organize this complicated  
24      picture to do this?

25      Q.    Is this a timed test?

1       A.    This is un-timed.

2       Q.    Is the person given an eraser?

3       A.    The patient -- the person is given an eraser, yes.

4       Q.    Go ahead.

5       A.    All right?

6               This was Megan's actual copy of the task. It  
7 doesn't look exactly right. Her performance is in the  
8 impaired range because the assumption is that most  
9 people will be able to draw this without a problem  
10 since it's un-timed and it requires no memory. The  
11 person's only -- it's a pure visual perceptual task.

12       Q.    Can you point out for us some of the errors that  
13 she made when she tried to copy from the left to the  
14 right?

15       A.    Okay. There are several areas. The first -- this  
16 is awfully tight.

17       Q.    It's hard to see, I know. You might want to look  
18 at your own copy.

19       A.    Yeah, that would help. Okay.

20               All right. The first thing you can see is --  
21 can people -- they can't see what I'm doing. The  
22 vertical cross on the far left of the figure --

23               MR. CHARNAS: Excuse me, Doctor. Is there some  
24 way she can move her finger and make highlights?

25               THE CLERK: Yes, she can touch the screen.

1 THE WITNESS: Oh, there it is. Oh, my goodness  
2 gracious. How do you move it? Sorry. I just messed  
3 it up.

4 MR. CHARNAS: I can clear it for you.

5 THE WITNESS: Okay, thanks.

6 A. That design is mostly right, but if you look at  
7 the master design, it's missing the tail of it. So,  
8 she doesn't get full credit for it.

9 The large rectangle, which you can see here, is  
10 made up of component parts. It's not a rectangle; it's  
11 four little boxes, and they're slightly different  
12 shaped, and it's not a rectangle. The top part up here  
13 is not straight. The six -- what is it? -- four  
14 parallel -- four parallel lines, which is right there,  
15 these four par -- there are five, one's partially  
16 erased, and they're not straight and -- because  
17 accuracy and placement is essential, and the placement  
18 is off.

19 The -- there was this small horizontal line  
20 above -- oh, I just made it again. Take it back.  
21 That's it. Right there. That line is crooked, it's  
22 not straight. All of those lose partial credit, all  
23 right?

24 The five parallel lines, horizontal cross.  
25 Okay. And the horizontal cross is cockeye -- no, not



1 the horizontal cross. The horizontal cross here is  
2 moving up, not straight.

3 Q. Where is that one? I'm sorry.

4 A. Down the bottom here.

5 Q. Can you press on it? Oh, there it is, okay.

6 A. There it is. This one here. She doesn't have it  
7 long enough, it's truncated, it's not in proportion to  
8 what the original design was.

9 Q. Is this test particularly sensitive to brain  
10 damage?

11 A. Yes, it is. It's extremely sensitive to brain  
12 damage.

13 Q. Explain that to the jury. Why is this test  
14 especially sensitive to brain damage?

15 A. It's one of the measures that looks at not only  
16 complex visual perception but underlying executive  
17 functioning, How does the person go about doing this  
18 task? Do they do it in a logical cohesive manner, or  
19 do they do it in a piecemeal and unusual truncated  
20 manner, looking at little segments rather than the  
21 whole picture?

22 Q. And a normal person wouldn't tend to do that?

23 A. No.

24 MR. CHARNAS: Can we go back to the camera?

25 Thank you.

1 Q. So, let's look at that functional implication  
2 column of these visual perceptual skills on the right.  
3 How did that manifest itself, this testing that she did  
4 and her performance on the testing in regard to visual  
5 perceptual skills?

6 A. The major problem for Megan was that she was  
7 always in front of a computer researching things,  
8 getting ready for the next meeting, doing her sales  
9 reports, and she was presenting problems with looking  
10 at the computer due to visual disturbances.

11 She had difficulty driving, turning her head in  
12 a car without dizziness and visual distortion. She was  
13 having real trouble keeping the world in its logical  
14 place. She -- the visual world was easily distorted  
15 and disturbed.

16 Q. Okay. Doctor, let's look at the next column on  
17 the left, you have, "Processing speed, fine motor  
18 skills." What's that?

19 A. Processing speed is how quickly one can do a task  
20 relative to your age group, your education group and  
21 your gender. And usually the assessment is done of  
22 fine -- gross -- fine motor skills, both for left and  
23 right hand, with a series of pegs that people have to  
24 put in a board or, relative to age group, Did the  
25 person complete a verbal task or a visual task within

1 an average period of time, a very fast period of time,  
2 very slow period of time?

3 Q. And some of her skills in that area were intact;  
4 correct?

5 A. Yes.

6 Q. And then move to the next column, some of those  
7 skills were in the weakness -- cognitive weakness  
8 column?

9 A. Correct.

10 Q. Explain, what are these fine motor abilities,  
11 right hand? What are you talking about there?

12 A. They're from the grooved peg board. It's a board  
13 where you have little key holes, and you've got pegs  
14 sitting in a pot, and the instruction is pick up one  
15 peg and put it -- one in each of the holes in a  
16 systematic way. The key holes are turned periodically  
17 on this display. The person is instructed to use your  
18 right hand only. If you drop it, leave it, I'll pick  
19 it up, but do it as rapidly as you can and complete all  
20 the pegs in the hole, and it's a board about yea by  
21 yea.

22 And they reverse, you'll do it with both the  
23 dominant and non-dominant hand. Megan's left-hand  
24 performance was in the average range. Megan's  
25 right-hand performance was in the low average range.

1 Q. So, how -- moving off to the right, how did that  
2 manifest itself in terms of functional problems she  
3 has?

4 A. Processing speed translates to it takes longer to  
5 do most anything. She complained of often was slow  
6 when completing reading tasks, when completing writing  
7 tasks. When she tries to speak, she finds she's  
8 slower. When she tries to think, it's slower. When  
9 she tries to learn, it's slower. So, the operating  
10 word is slower in activities normally involved with  
11 cognition. She also said she's moving slower, she  
12 lacks energy, and she's inactive.

13 Q. Let's get to the second page of your work, "Memory  
14 Abilities," basically that's remembering things?

15 A. That's remembering things --

16 Q. All right.

17 A. -- and it's remembering things that you hear  
18 verbally and remembering things that you hear  
19 visually -- that you see visually, Is one area stronger  
20 than the other? And does complexity make a difference?  
21 If it's simple information, Do you remember it better,  
22 or if it's complex, do you remember it better?

23 Q. And she's retained some real strengths in that  
24 area; correct?

25 A. Yes, she has.

1 Q. Tell us about the strengths.

2 A. One strength was in the California Verbal Learning  
3 Test, which is that it's a mixed-up laundry list of  
4 items that are 16 items long, it's got names of  
5 transportation and foods and various different  
6 categories, but you wouldn't know it when you heard it.  
7 It's a mix -- it's all mixed up together.

8 The first time she heard that list, she  
9 remembered a strength at 84th percentile for her age  
10 group. She could hold on to that information the first  
11 time she heard it. That would be called learning, you  
12 know, short-term memory for unstructured information.

13 Q. And she had other skills in that area that she was  
14 average at -- correct? -- in the next column?

15 A. That's correct.

16 Q. And let's talk about the cognitive weaknesses in  
17 the memory abilities in the next box over.

18 A. Okay.

19 Q. What is this "LTM unstructured but repeated verbal  
20 information"? What does that mean?

21 A. All right. The short-term memory, which is STM --  
22 that's a shorthand just to fit it on the chart here --  
23 for simple visual information, she was shown simple  
24 visual designs like the figure X with little flags on  
25 each of the ends of the Xs -- on each of the ends of

1 the X, and she was shown the design, the design was  
2 removed, and she needed to copy it on to a page. She  
3 did very well the first time she saw that design for --  
4 the first time she did it.

5 The -- structured verbal -- the -- all right.  
6 Let me backtrack. The verbal learning list that I  
7 talked about that she did so well the first time she  
8 heard it gets repeated five different times for her,  
9 and each time she needed to repeat back the information  
10 to me. Her short-term memory for that information that  
11 was repeated declined to the average range but still  
12 was intact for her. She had some loss of the  
13 information, but it didn't -- it was certainly in the  
14 average range.

15 She did better, however, when things were  
16 structured in the verbal world. Her short-term and  
17 long-term memory for a story -- there were two stories  
18 read, but the stories had a beginning, a middle and an  
19 end to them, and that structure helped her remember  
20 that information both the first time she heard it and  
21 the second time she heard it, with her performance in  
22 the average range. So, here we have some positive  
23 strengths in verbal memory skills.

24 There are some losses, however, and --

25 Q. Tell us about that.

1       A.    Shall I go on?

2       Q.    Yes.

3       A.    The information, that verbal list that she learned  
4       so many times, in the long term, her performance  
5       dropped to the low average range, which, even with  
6       repetition, she was unable to hold on to it after a  
7       30-minute delay where some other task was done.

8               And more alarmingly, when she took that simple  
9       information that she had remembered in the average  
10      range the first time she saw it, there were five  
11      different designs, she was down to the second  
12      percentile, which is in the impaired range at 30-minute  
13      delay. So, she lost the majority of that information.  
14      There were five pictures. She remembered the first one  
15      accurately, which was the simplest. She reversed the  
16      information on the second one, and she couldn't  
17      remember any of the last three designs.

18             The Rey Complex Figure, which we had up a little  
19      while ago, is not only a visual perceptual task, but  
20      it's a memory task because we have Megan draw the  
21      picture, and we saw how she did the drawing and how  
22      disorganized it was, and then unexpectedly I then say,  
23      Draw the figure for me from your memory. The first  
24      time she saw it and 30 minutes later, she had impaired  
25      performance on this complex visual memory measure.

1 Q. Dr. Hibbard, apart from the test of her efforts  
2 that you talked about before, did you have an  
3 opportunity to observe her working on these tests?

4 A. Yes, I did.

5 Q. And did you make any observations about her  
6 efforts on these tests?

7 A. She was trying the hardest she could. She was  
8 extremely frustrated when she realized she couldn't do  
9 something or she had forgotten something. In one task,  
10 she lost the set of what she was doing and started  
11 doing her own version of the test and then realized  
12 halfway through it, This is not what I'm supposed to be  
13 doing. So, she was an acute observer of her behaviors  
14 and most distressed at them.

15 Q. So, let's move off to the right column now, and  
16 tell us about how -- the functional implications of  
17 these memory issues you were telling us about.

18 A. She had many. She often forgets what she just  
19 said, she forgets what happened yesterday, she often  
20 loses her train of thought, which is the example I just  
21 gave you in the testing, she often forgets to turn off  
22 appliances. That's a safety issue.

23 She sometimes gets lost in the community.  
24 That's not only attention, but it's memory, Where was I  
25 going? She forgets to do chores, and she learns



1 slowly. All of those are illustrations of functional  
2 problems with memory.

3 Q. Doctor, the last column here, "Executive  
4 Functioning Skills," tell us, what are exec -- I think  
5 you touched on it before, but tell us, what are  
6 executive functioning skills?

7 A. Executive functioning skills include things such  
8 as problem-solving, flexible thinking, organization,  
9 ability to inhibit responses, ability to monitor what  
10 you're saying.

11 Q. And did she have any -- she had no cognitive  
12 strengths high average or above in that area?

13 A. That's correct.

14 Q. In terms of average, she had some average skills  
15 in that area; correct?

16 A. That's correct.

17 Q. Tell us about that in that column.

18 A. Verbal abstract thinking, the person -- she would  
19 be presented with two items that don't, on surface,  
20 seem to be related, like music and tides and asked, How  
21 are music and tides alike? What do they have in  
22 common? That level of abstract thinking requires you  
23 to think flexibly about two things that don't normally  
24 go together. And on that particular task, she was in  
25 the average range.

1 Her rapid shifting of moving on -- from one  
2 thing to another on visual tasks was also in the  
3 average range. Somehow moving from thing to thing to  
4 thing was discombobulating for her. And you can see  
5 that on a Picov's Trails Test.

6 Q. Now, what about the next column over? What were  
7 her cognitive weaknesses in these executive functioning  
8 skills?

9 A. She was having trouble inhibiting. Remember the  
10 task of sustained attention where she needed to look at  
11 things flashing on a computer and not touch the space  
12 bar when she saw the letter X. She couldn't inhibit  
13 that response. There were other tasks that looked at  
14 inhibition, and she had trouble managing those tasks.

15 Her simple mental set-shifting is just going  
16 from one task to another, her ability to do that was  
17 very compromised. She did better if she stayed on one  
18 task without changing back and forth. And her visual  
19 abstract thinking was in -- is a weakness, and it was  
20 and was previously described.

21 Q. Let's talk about cognitive impairments in the  
22 executive functioning skills.

23 A. There she had a significant array, unfortunately.  
24 Her complex mental set-sifting, she could do shifting  
25 simply from one task or one component thing to another;

1 but when things became more complex, her performance  
2 declined dramatically and were in the borderline or  
3 impaired range.

4 Her flexible problem-solving was in the impaired  
5 range, and this task was called the Wisconsin Card-Sort  
6 Test, and it was a test -- it was kind of like a  
7 computer game. The person saw four cards on a visual  
8 computer and a deck of cards, and the person had to,  
9 based on feedback from the computer, figure out what  
10 placement one of these four cards should they stack the  
11 new card on to. It was a sorting task.

12 Unbeknownst to the person, the task kept  
13 changing. Sometimes you had to match the card to the  
14 color of the stimulus cards, there were different  
15 colors, yellow and red and green and blue. Other times  
16 it was the shape of the card, there were hearts and  
17 diamonds and clubs. And other times it was the number  
18 of items, there were three hearts or two clubs or  
19 things like that.

20 Her ability to take feedback and be able to  
21 shift on spot and problem-solve another way of tackling  
22 the problem was extremely limited. She was very  
23 frustrated at this task, and her performance was  
24 clearly in the impaired range for her IQ. Her ability  
25 to inhibit responses, that's also part of this, I

1 mentioned already.

2 Q. What does that mean?

3 A. Inhibiting responses, not responding when you  
4 wanted to. There was one task where she was asked to  
5 read words, and the words were the words "blue, red" or  
6 "green" as rapidly as she could. She did fine on that.  
7 It's a speeded task.

8 Then she was asked to have -- there was a page  
9 with just Xs on it, and the Xs were in red, blue or  
10 green, and she needed to tell you the color of the Xs,  
11 and she would say, Red, green, blue, green, whatever  
12 color.

13 The third part, and this is a Stroop -- a  
14 Stroop-like test, it's part of the B Test battery. The  
15 third test was what they call an interference test  
16 where she had to ignore the word but tell you the color  
17 of the ink it was printed in. So, you'd see the word  
18 "red" but it would be in blue ink, and the answer would  
19 be blue. And then you'd see the word "green," but the  
20 word "green" would be printed in red ink, and the  
21 answer would be red because the instruction was to tell  
22 the color of the ink. She struggled with that task.

23 Q. What does that tell you?

24 A. It is your ability to in -- you can inhibit  
25 distraction and still maintain your focus on what the

1 task is that you need to do.

2 Q. Can you give an example of how that would manifest  
3 itself in life?

4 A. Well, it manifests itself as impulsivity, the  
5 person just does; they don't stop and think. Even if  
6 the feedback is telling them maybe this is not what  
7 they should do, they still do it.

8 Q. Go ahead. I didn't mean to interrupt you.

9 A. Her verbal output, her monitoring of verbal  
10 output, she had no idea, on the California Verbal  
11 Learning Test, that she had said the word five times  
12 before or not. She just repeated it as if it was a  
13 novel bit of information that she was telling you.

14 Her conceptual thinking skills, or her overall  
15 executive level of functioning, and those also were in  
16 the impaired range, and that was based on that  
17 card-sorting task. And it was unstructured, which  
18 is -- was her nemesis, so those are the impaired ones.

19 Q. Doctor, this is the last box on the cognitive  
20 function. The functional implications of these  
21 executive functioning skills difficulties, tell us  
22 about those.

23 A. These are ones that she reported at -- when I  
24 first interviewed her, and she had also endorsed them  
25 on the checklist before I interviewed her. She often

1 had difficulty making decisions, she often had  
2 difficulty solving problems, she often couldn't plan  
3 future events or set priorities.

4 She had difficulty following instructions, she  
5 had difficulty learning from new -- learning from  
6 experiences, she had difficulty coping with unexpected  
7 change, she frequently mixed up the sequence of events,  
8 she rarely thought before acting. That's that  
9 impulsive component, she frequently shows poor  
10 judgment, she frequently reports she's disorganized,  
11 and she's rarely able to plan ahead.

12 Q. Now, Doctor, I think you mentioned that you also  
13 checked -- tested for affective functioning?

14 A. That's correct.

15 Q. Let's take a look at that.

16 THE COURT: Before you change exhibits, we're  
17 still about half an hour from lunch, but why doesn't  
18 everybody stand up and stretch a little bit and move  
19 around. We'll have a long stretch here.

20 THE WITNESS: That's a good idea.

21 (Pause)

22 THE COURT: Mr. Charnas, when you're ready.

23 Q. Ready, Doctor?

24 A. Yes.

25 Q. Thank you. Tell us now, in terms of these

1 affective dysfunction that you tested for, mood  
2 disorders, what's that?

3 A. A mood disorder is the psychological and  
4 psychiatric terminology for a depression. There can be  
5 different levels of depression, there can be, you know,  
6 mild depression, major depression, and there can be  
7 major depression associated with medical conditions,  
8 for example, different kinds of medical conditions.

9 It, in this case, does not focus or include  
10 things such as mania or bipolar disorder or things like  
11 that. The focus of my assessment was to look at, Is  
12 Megan depressed, and if so, how depressed? And,  
13 secondly, is she potentially suicidal? Those are the  
14 three concerns I have, given the literature on  
15 traumatic brain injury.

16 Q. And what did you find?

17 A. That Megan met criteria for a moderate depression  
18 based on her self-report. There was a 21-item measure  
19 called the Beck Depression Inventory, and it  
20 specifically asks her about her mood, her overall  
21 energy, whether she's pessimistic or not, whether she's  
22 guilty or feeling punished, question about suicide  
23 issues or intent as well as things like crying,  
24 agitation, loss of interest, difficulty making  
25 decisions, concentration, sleep and fatigue, loss of

1 sexual interest.

2 Her report there was in the moderate depressed  
3 range, and it certainly was congruent with my  
4 observations of Megan. She was in tears many, many  
5 times during the interview.

6 Q. Couldn't she just make up any answer she wanted  
7 for that Beck Depression Test you mentioned?

8 A. I think that's possible, but what I have is  
9 clinical observation of the person as well as going  
10 through each of these items and asking her more about  
11 them, so I had a better read of why she rated herself  
12 as she did.

13 Megan was not suicidal at this point, so I was  
14 relieved at that. But I do, do a screen of the items,  
15 look at her self-report and her clinical behaviors over  
16 eight hours to have a sense of what her mood is like.

17 Q. And the final column, "Anxiety Disorders," what  
18 are anxiety disorders?

19 A. Anxiety disorders are a mixture of different  
20 sub-types of anxiety disorders. They can be all the  
21 way to phobias to post-traumatic stress disorder.  
22 People can have generalized anxiety or specific anxiety  
23 to an item or a cluster of things.

24 Q. You found she had mild anxiety?

25 A. She had mild anxiety. I used the Beck Anxiety



1 Inventory, and it questioned things like, Are you  
2 unable to relax, which she said she had a mild problem  
3 with, dizziness or lightheaded; your heart pounding for  
4 no reason, she said, I don't know; feeling terrified,  
5 she said that was a mild problem; feeling nervous she  
6 said was mild; she felt shaky, she felt losing control  
7 at times, fear of dying and feeling scared. Those were  
8 all mild problems for her.

9 Q. Then you have, in this column to the right of  
10 that, "Mild Traumatic Stress Disorder." What's that?  
11 I'm sorry. "Post-traumatic stress disorder." My  
12 apologies.

13 A. I was going to say I think I did that one.

14 She alluded to, on the clinical interview -- on  
15 this depression -- brain injury screening  
16 questionnaire -- pardon me -- that she was having  
17 flashbacks. It's one of the items within the cognitive  
18 domain that's asked of the hundred items.

19 She also was talking about having problems with  
20 anger control, and I routinely now give a  
21 post-traumatic stress disorder checklist as a screen to  
22 see if this is a potential problem because current  
23 literature is pointing to an increased frequency of  
24 post-traumatic stress disorder after a traumatic brain  
25 injury.

1 Q. Isn't post-traumatic stress disorder what  
2 people come -- soldiers come back with from Iraq and  
3 Afghanistan?

4 A. They also come back with traumatic brain injuries.  
5 But yes, that is true. It is a very common sequelae of  
6 a horrific or near life-threatening event. That's the  
7 first criteria for post-traumatic stress disorder.

8 I think in Megan's case, having a 100-pound  
9 umbrella flying towards her face is a pretty traumatic  
10 event with child in hand. She did have flashbacks of  
11 this accident. I did explore them in greater detail.  
12 She could see the umbrella or she'd be dreaming this,  
13 she'd wake up shaking at night with the dream. So, she  
14 has the life-threatening event.

15 She also has problems with avoidant behavior,  
16 which is another criteria for post-traumatic stress  
17 disorder. She -- for example, this -- on this  
18 checklist, she avoids thinking about or talking about  
19 past stressful experiences in her life. That's an  
20 avoidance issue. She avoids situations because they  
21 remind her of a stressful event. She has trouble  
22 remembering important parts of the stressful event.  
23 And she's begun to lose interest in things that she  
24 used to enjoy. Those are beginning to look at  
25 avoidance kinds of issues.

1           She also has -- the last criteria, which is  
2       arousal issues, she's got heightened arousal or  
3       hypervigilance, always watching, being careful. On her  
4       clinical interview, she reported in detail her fear  
5       that, if she was with the kids, she would -- her  
6       children, she would be afraid she couldn't protect them  
7       enough, and if she was away from her kids, something  
8       awful was going to happen to her -- to them. That's a  
9       very classic hypervigilance kind of reaction.

10      **Q.**    So, do you have an opinion as to whether she  
11       suffers from post-traumatic stress disorder as a result  
12       of this incident?

13      **A.**    Well, she certainly meets all four criteria for  
14       the diagnosis, yes, she does. And some of the items  
15       that I picked from the checklist that she filled out  
16       were that she did have flashbacks of the accident, she  
17       often had difficulty dealing with people, she felt  
18       uncomfortable around other people, and she had  
19       difficulty being in crowds. Those are very traditional  
20       of military who've had post-traumatic stress disorder,  
21       but for Megan, this was obviously new since the  
22       accident and the injury.

23      **Q.**    Now, earlier when you testified, you mentioned  
24       that other physicians had diagnosed Megan with mild  
25       traumatic brain injury; do you remember that?

1 A. That's correct.

2 Q. Which physicians; do you recall?

3 MR. LAWLER: Objection.

4 THE COURT: She can answer that question.

5 A. There were a series. In the emergency room -- no.  
6 In the -- yeah, EMS reports, Emergency Medical Services  
7 report, she had a -- the diagnose of head trauma was  
8 not used specifically, but head swelling was, with  
9 confusion and --

10 MR. LAWLER: Objection, Your Honor.

11 THE COURT: Sustained.

12 Q. Let me try this differently.

13 A. Okay.

14 Q. In reading the records, were there physicians who  
15 treated Megan Irwin who specifically diagnosed mild  
16 traumatic brain injury?

17 A. Yes, there were.

18 Q. Can you tell us which physicians?

19 A. I don't have the specific name of the physician in  
20 the emergency room, but head trauma with concussion was  
21 the diagnosis.

22 MR. LAWLER: Objection.

23 THE COURT: Sustained.

24 A. A general practitioner two days after the injury;  
25 a neurologist five weeks after the injury, Dr. Sun; a

1 neurologist/psychologist, Dr. Brown, who did some  
2 testing on Megan; Dr. Stone with a concussion center in  
3 Pittsburgh about a year after her injury; a follow-up  
4 with Dr. Stone with the continued diagnosis; and two  
5 MRIs.

6 Q. What about doctors at Rusk in New York?

7 A. I have looked at new medical records on Megan to  
8 see what was happening with her, and she is being seen  
9 by a physiatrist who is the specialist in  
10 rehabilitation medicine and diagnosed there.

11 Q. Is that Dr. Im?

12 A. That's Dr. Im, yes.

13 Q. Oh, I'm sorry.

14 A. And a neurologist, Dr. Halpern, who is attempting  
15 to address Megan's diagnosis of TBI and migraines.

16 Q. Doctor -- there may be more, but you can stop  
17 there -- is it your opinion that these symptoms, these  
18 weaknesses and impairments in cognitive and affective  
19 functioning are consistent with mild traumatic brain  
20 injury?

21 A. In my opinion, yes.

22 Q. Now, Doctor, you've touched on this a moment ago.  
23 You saw her back in the spring of 2014. Have you in  
24 fact read medical records of her treatment since that  
25 time up to -- through 2015?

1       A.    Yes.

2       Q.    And you had said in your report that Megan should  
3       engage in certain rehabilitation measures or treatment  
4       measures; do you remember that?

5       A.    Treatment recommendations.

6       Q.    Treatment recommendations, thank you.

7                Would you tell us what they were back in the  
8       spring of 2014?

9       A.    Yeah.  One second.

10               My first recommendation was that Megan should  
11       see a physiatrist within rehabilitation medicine who  
12       was focused on treatment of individuals with traumatic  
13       brain injury, and then I suggested several things that  
14       should be considered when seen by this physiatrist.  
15       I'll skip those for now and move on.

16       Q.    Yes.

17       A.    The second recommendation was that, given that  
18       traumatic brain injury is a chronic medical disability,  
19       that she's going to need lifelong follow-up by a  
20       physiatrist.  This cannot be short-term but ongoing and  
21       what recommendations would be needed as Megan ages with  
22       her traumatic brain injury.

23               I recommended that Megan be seen for intensive  
24       psychological services by a rehabilitation  
25       psychologist, someone in the field of rehabilitation

1 who's familiar with treating the combined emotional  
2 problems of individuals with brain injury, in Megan's  
3 case, depression and anxiety and PTSD.

4 The -- she would also require intensive  
5 cognitive remediation. Cognitive remediation can be  
6 provided by several professionals in the field and  
7 often do collaborate on these, but clearly she needed  
8 to be educated about her brain injury and then begin to  
9 address some of these impairments and weaknesses  
10 identified.

11 After completing psychotherapy and remediation,  
12 it's anticipated that, much like the patient would need  
13 ongoing medical oversight, most likely she will need  
14 ongoing psychological oversight in less intensity and  
15 that, that will be ongoing, in all probability, for the  
16 rest of her life. This is to deal with any unexpected  
17 events in her life as well as changes in her  
18 functioning.

19 I recommended that the Irwins be seen in family  
20 therapy because there was a lot to understand about  
21 changes in Megan since the injury, and it needed to be  
22 psycho-educational and supportive in nature. I reco --

23 Q. Go ahead. I'm sorry.

24 A. I recommended that she been seen for vocational  
25 counseling but only after she had done fairly intensive

1 treatment at the front end here before she actually  
2 even considered trying to return to work because she  
3 needed to take her new self and recognize her strengths  
4 and weaknesses before she went back to any work trial  
5 if she could.

6 I recommended that she not drive at this point  
7 and that she should undergo a driver evaluation before  
8 she tries to get back to that.

9 She was in vestibular therapy, which was a  
10 treatment for ongoing dizziness and nausea that she had  
11 as a result -- and visual problems that she had  
12 secondary to a traumatic brain injury. I recommend  
13 that she continue doing that.

14 I also felt she needed more childcare help at  
15 home because she couldn't manage the three children as  
16 she had done pre-injury. And in order to have her come  
17 for intensive treatment, that's very time-consuming, so  
18 she would need extra help at home to manage and  
19 oversight the kids.

20 I recommended that she undergo  
21 neuropsychological evaluation every five years, and the  
22 purpose of the evaluation was to see if things had  
23 gotten worse or better over time and if there were  
24 changes that were needed in her treatment regime.

25 I encouraged to continue her medical follow-up



1 with her general practitioner but that her physician  
2 needed to work collaboratively with the rehab team.  
3 Same -- she was seeing an otolaryngologist because of  
4 problems that she was having related to the injury and  
5 that, that person needed to be linked in to the team.

6 I recommended independent couples therapy for  
7 Mr. and Mrs. Irwin once she finished rehabilitation  
8 services. The first part was just to learn about brain  
9 injury and how to cope with it. This now is working on  
10 family issues that typically arise or get worse after  
11 an injury of this nature and that copies of this report  
12 should be shared with the patient, the family and all  
13 treating personnel.

14 Q. Dr. Hibbard, you've read those newer records since  
15 spring of 2014. Did you note any significant  
16 improvement in any of Megan's symptoms?

17 A. No, I did not.

18 Q. Doctor, do you have an opinion as to what type of  
19 environment would be conducive to --

20 A. I take that back. There is one.

21 Q. Oh, I'm sorry.

22 A. She's learning, learning with accommodations how  
23 to present herself in a more organized fashion. That  
24 seems to have gotten slightly better. Her vestibular  
25 problems, her vision problems, her other cognitive

1 problems are still causing functional difficulties.

2 Q. Dr. Hibbard, what type of environment would be  
3 conducive to Mrs. Irwin's maximal functioning?

4 A. A low-stimulation environment for sure, one where  
5 she can stay focused on tasks to completion rather than  
6 shifting back and forth; an environment where she can  
7 take frequent rests because she quickly cognitively  
8 burns out and needs to remove herself from her  
9 environment.

10 Q. Do you have an opinion as to whether she could  
11 find actual employment with an environment such as you  
12 describe?

13 A. At the point I wrote this report, I didn't know.  
14 Seeing the chronicity of her --

15 MR. LAWLER: Objection. Request sidebar.

16 (Discussion at sidebar)

17 MR. CHARNAS: That's a surprise to me, Judge.  
18 So, I'll ask a different question.

19 THE COURT: Okay.

20 MR. LAWLER: I want the question stricken.

21 MR. CHARNAS: I have no problem with that.

22 THE COURT: Okay. How much more do you have  
23 left on direct?

24 MR. CHARNAS: Very little. Five minutes.

25 THE COURT: Okay.

1 (End of discussion at sidebar)

2 THE COURT: The objection is sustained. The  
3 question is struck.

4 Q. Dr. Hibbard, what's a vocational counselor?

5 A. A vocational counselor is an individual who has  
6 studied vocational psychology typically and is an  
7 expert on job descriptions, occupational handbooks of  
8 work, things like that. They will often provide  
9 guidance for individuals about if they can work and, if  
10 so, what would be ideal environments for them.

11 Q. Are you a vocational counselor?

12 A. No, I am not.

13 Q. When it comes to making a determination as to  
14 whether Megan Irwin could actually find employment,  
15 given her impairments, would you defer to the opinion  
16 of a vocational counselor?

17 A. Ultimately, I would.

18 Q. Now, do you have a prognosis in regard to her  
19 cognitive and affective dysfunction that you described  
20 for us?

21 A. Her prognosis, in my professional opinion, is  
22 guarded.

23 Q. And what does guarded mean?

24 A. Meaning that the nature of her injury and the  
25 long-term chronicity of her problems will continue

1       onward rather than dissipate; her overall level of  
2       functional improvement over time will be minimal  
3       because impaired brain function is impaired brain  
4       function and that, to the extent she has learned  
5       compensatory strategies, she may function better,  
6       slightly better, but there will not be a dramatic  
7       return to the level she was before.

8               MR. CHARNAS: Thank you, Doctor.

9               Those are all the questions I have, Your Honor.

10              THE COURT: Okay. Why don't we take our lunch  
11       break now. And as I said, we'll have a shortened lunch  
12       break, but you have lunch upstairs waiting for you, so  
13       we'll -- Ms. Folan will come back to get you in about  
14       30 or 35 minutes, okay? Thanks, everyone.

15              THE CLERK: All rise for the jury.

16              (The jury is not present for the following)

17              THE COURT: So, what we'll do, we'll come back  
18       in about half an hour, you'll start your cross of her,  
19       we'll break at 2:00, I'll give them a short break,  
20       we'll swap witnesses, and you'll do your direct  
21       examination of the next witness.

22              MR. LAWLER: Okay. Your Honor, I -- just for an  
23       administrative matter, I would like -- I think  
24       Dr. Hibbard's report should be marked an appellate  
25       exhibit. It's not an -- she's been reading from it

1 along with her CV. I mean, there should be some record  
2 I think --

3 THE COURT: We'll mark it as an exhibit.

4 MR. LAWLER: Thank you. It's a non -- it's an  
5 exhibit that's not going to go to the jury, obviously.

6 THE COURT: Correct.

7 MR. LAWLER: Okay, that's all. Thank you.

8 THE CLERK: Court is in recess.

9 (Recess at 12:54 p.m.)  
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C E R T I F I C A T I O N

I, Debra D. Lajoie, RPR-FCRR-CRI-RMR, do  
hereby certify that the foregoing pages are a true and  
accurate transcription of my stenographic notes in the  
above-entitled case.

/s/ Debra D. Lajoie

5/18/16